10/28/04 Wiregrass Medical Center PAGE 1
13:18 Thursday PATIENT ACCOUNT DETAIL 467551 SEAMAN CRYSTAL D H5ARDET

WIREGRASS MEDICAL CENTER
1200 W MAPLE AVE
GENEVA AL 36340-1694
PHONE: 334-684-3655 TAX ID#: 636004474

PATIENT----------
1 NUM/NAME-: 467551 SEAMAN CRYSTAL D
2 SEX------: M
3 BIRTH----: 03/09/1970
4 DOCTOR---: 006400 BERANEK ST
5 MARITAL--: M
6 SOC.SEC.-: 236150086

BILLING INFORMATION----------
16 CREDIT----: HOSP DRG..:
17 BILL------: FINAL DRG.:
18 CYCLE-----: 2
19 STAY TYPE-: 2 O/P
20 SERVICE---: R
21 INSURANCE-: GB5 NATIONAL SECURITY

GUARANTOR----------
10 NAME-----: SEAMAN CRYSTAL D
11 ADDRESS-1: 28045 BEULAH CH ROAD
12 ADDRESS-2:
13 CITY/ST--: OPP AL
14 ZIP------: 36467-0422
15 PHONE----: 3348585904

ADMISSION----------
22 DATE------: 6/02/03
23 CODE------: N

DISCHARGE----------
25 DATE------: 6/02/03 DAY STAY
26 CODE------: H

A/R DATE	SERV DATE	TYPE TRAN	CODE	CHG/REC NUMBER	QTY	DESCRIPTION	CHARGE	CREDIT	MED NECESSARY	CPT
06/02/03		CHG	320	24700001	1	<=X-RAY ORDER=>	.00			
06/02/03		CHG	320	24731107	1	WRIST 4V	87.00			73110
06/17/03		PAY		113907		GB5 NATIONAL SECURITY		13.00		
10/01/03		CHG		99001	1	BAD DEBT WRITE-OFF		74.00		

BAD DEBT BALANCE.....74.00 AR BALANCE.....0.00

PLAINTIFF'S EXHIBIT 14a
Blumberg No. 5113

WIREGRASS MEDICAL CENTER 1200 W MAPLE AVE GENEVA AL 36340

EMERGENCY ROOM • OUTPATIENT RECORD

PATIENT NUMBER	TYPE	PATIENT NAME	AGE	BIRTHDATE	SEX	M/S	DATE OF SERVICE	TIME	CLERK INIT.
467551	2	SEAMAN CRYSTAL D	33	3/09/1970	M	MW	6/02/03	09:13	MAM

ADDRESS - LINE 1	ADDRESS - LINE 2	CITY	STATE	ZIP CODE	TELEPHONE
783 GOPHER RIDGE RD		SAMSON	AL	36477	334-858-5904

PATIENT SSAN	NOTIFY IN CASE OF EMERGENCY - NAME	RELATIONSHIP	ADDRESS	TELEPHONE
236150086	SEAMAN ROBERT	SP	SAME SAMSON AL	334-858-5904

INSURANCE COMPANY	CONTRACT OR GROUP NUMBER	DATE	PLACE	ACCIDENT
NATIONAL SECURITY	226150086	3/25/03		
		TIME	EVENT	
			INJ TO R WRIST	

GUARANTOR NAME	GUARANTOR ADDRESS	CITY	STATE	ZIP CODE	GUAR. TELEPHONE	GUARANTOR
SEAMAN CRYSTAL D	783 GOPHER RIDGE RD	SAMSON	AL	36477	858-5904	

GUARANTOR EMPLOYER	GUARANTOR OCCUPATION	GUAR. EMPLOYER ADDRESS	GUAR. EMPL TELEPHONE
STUDENT MCARTHUR TECH	STUDENT		

PREV. SERVICE	PREV. SERV. DATE	IF MINOR - PARENT NAME	MED. REC. #	ADMITTING/2ND PHYSICIAN
465658	4/30/03		236150086	BERANEK ST/MITCHUM O

CHARGES	X-RAY	LAB	RESP. TH.	PHY. TH.	EKG	I.V.	DRUGS	SUPPLIES	OTHER	M.D.	E.R. RM	TOTAL DUE

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT , ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned has been informed of the emergency treatment considered necessary for the above named patient, and that treatment and procedures will be performed by physicians, members of house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.
2. The undersigned agrees to pay for services rendered by Hospital upon release of patient.
3. I we hereby assign any hospital benefits, sick benefits, injury benefits due to a liability of a Third party, payable by any party, for the above patient, to Hospital unless I pay the account in full upon release of patient.
4. I/we hereby authorize the "Administrator of Hospital" to furnish from its records any information requested by the before mentioned insurance companies in connection with the above assignment. I do hereby appoint the "Controller" of Hospital as my lawful attorney to endorse for me any checks made payable to me for benefits or claims collected under the above assignment and to apply any credit balance to any other account I may owe said hospital.

DATE TIME SIGNED PATIENT SIGNED GUARANTOR

CHIEF COMPLAINT (If Accident State How, When, and Where)

R WRIST PAIN

TEMP.	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - HOME	E.R. PHYSICIAN	TET. TOX.

NURSES NOTES:

NURSE'S SIGNATURE (RN OR LPN)

LAB DATA (Including X-Rays, EKGs, etc.)

PHYSICIAN'S REPORT

Blumberg No. 5113 PLAINTIFF'S EXHIBIT 146

DIAGNOSIS:

TREATMENT:

CONDITION ON DISC: IMP | STABLE | EXPIRED

INSTRUCTIONS TO PATIENT:

FOLLOW-UP WITH M.D.

PATIENT'S SIGNATURE ON DISCHARGE
SIGNING HERE I CERTIFY THAT I UNDERSTAND THE FOLLOW-UP INSTRUCTIONS RECEIVED BY ME IN WRITING, WHICH WERE EXPLAINED TO ME.

DATE - TIME OF DISC.

PHYSICIAN'S SIGNATURE M.D.

Wiregrass Medical Center
1200 W. Maple Avenue
Geneva, Alabama 36340

CONDITIONS FOR TREATMENT

467551 Seaman, Crystal

1. **MEDICAL AND SURGICAL CONSENT FOR TREATMENT:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.

2. **RELEASE OF INFORMATION:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.

3. **RELEASE FROM LIABILITY FOR VALUABLES:** I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.

4. **GUARANTOR AGREEMENT:** The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

5. **ASSIGNMENT OF INSURANCE BENEFITS:** In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Date 6-2- 20 03

Witness Becky Shehee

Crystal Seaman 6-2-03
Patient

Patient's Agent or Representative

Relationship to Patient

ASSIGNMENT OF MEDICARE BENEFITS:
PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part A deductible for each spell of illness, the Part B deductible for each year, the remaining 20% of reasonable charges and any personal charges incurred."

Date | Signature | Relationship to Patient

ACKNOWLEDGEMENT OF MEDICARE

I hereby declare I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be considered a self-pay patient required to pay in full immediately.

Date | Signature | Relationship to Patient

WIREGRASS MEDICAL CENTER

1200 WEST MAPLE AVENUE
GENEVA, ALABAMA

RADIOLOGY REPORT

NAME: SEAMAN CRYSTAL D
AGE: 33 **SEX:** M
DOB: 03/09/1970
STAY TYPE: O/P ROOM:
ADMIT DATE: 06/02/03
ACCT NUMBER: 467551
LOCATION:
TRANS DATE: 6/03/03

PATIENT PHONE: 334/858/5904
ORDERING PHY: BERANEK ST
ADMITTING PHY: BERANEK ST
REFERRING PHY: MITCHUM O
FAMILY PHY: MITCHUM O
XRAY NUMBER: 20539
MR NUMBER: 236150086
TRANS INITIALS: SR

<=X-RAY ORDER=> COMPLETE:06/02/03 9:31 ERH 44258
Reason for Procedure: RT WRIST PAIN
WRIST 4V 73110 COMPLETE:06/02/03 9:32 ERH 44264

*** UNSIGNED TRANSCRIPTIONS REPRESENT A PRELIMINARY REPORT AND DOES ****** NOT REFLECT A MEDICAL OR LEGAL DOCUMENT ***

RIGHT WRIST 4 VIEWS INCLUDING TUNNEL VIEW FOR THE HAMATE: THE HOOK OF THE HAMATE APPEARS TO BE INTACT. JOINT SPACES ARE MAINTAINED. THERE IS NO FRACTURE SEEN.

OPINION: UNREMARKABLE EXAM.

JOHN C. TOMBERLIN, M.D.

WIREGRASS MEDICAL CENTER
1200 W. Maple Ave.
Geneva, AL 36340
(334) 684-3655 voice
(334) 684-6564 fax

4607551

Patient Name Crystal D. Sanders

SS# | DOB

Phone | Precertification #

Scheduled Date & Time

Physician Signature [signature] Date 6/4/03

OUTPATIENT PHYSICIAN ORDERS

Diagnosis (essential for registration) (R) wrist pain

	STAT & CALL RESULTS		SEND RESULTS BY COURIER
	FAX TO PHONE #		SEND RESULTS BY MAIL

Laboratory

	AMYLASE		LIPID PROFILE		RA PROFILE
	ANA		HEPATIC PANEL		RA TEST
	B12 / FOLATE		MONO TEST		SED. RATE
	CALCIUM		PHENOBARBITAL		SGOT
	CBC		POTASSIUM		TEGRETOL LEVEL
	CHOLESTEROL		PREGNANCY, Urine		THEOPHYLLINE
	CULTURE from...		PREGNANCY, Serum		THYROID PROFILE
	DEPAKOTE LEVEL		BASIC METABOLIC PANEL		TRIGLYCERIDES
	DIGOXIN LEVEL		COMPREHENSIVE METABOLIC PANEL		LITHIUM
	DILANTIN LEVEL		PROTHROMBIN TIME		URINE CULTURE
	GLUCOSE		PSA		URINALYSIS
	Hgb A1C		PTT		

OTHER, as follows...

Respiratory Care

	ABG		PULMONARY FUNCTION TESTING
	PULSE OXIMETRY SPOT CHECK		BASIC
			COMPLETE
			WITH / WITHOUT — BRONCHO-DILATOR

OTHER, as follows...

Physical Therapy

	EVALUATE & TREAT		PROSTHETIC TRAINING		WHIRLPOOL / WOUND CARE
	MODALITIES		TENS UNIT		STRENGTHENING / ROM EX
	GAIT TRAINING		TRACTION		

OTHER, as follows...

Imaging Services

	ULTRASOUND		C.T.	CONTRAST Y	CONTRAST N		NUCLEAR MEDICINE
	ABD		ABD				BONE
	ARTERIAL		HEAD				HIDA
	BREAST		PELVIS				THYROID
	CAROTID		L.S.				
	ECHO		C.S.				
	PELVIS						
	VENOUS						

OTHER, as follows...

X-RAY

L	R		L	R		
		ANKLE			HUMERUS	
		CLAVICLE			FEMUR	
		CHEST			G.I.	
		ELBOW			FINGER	Specify Digit
		FOOT			TOE	
		FOOT & ANKLE			KNEE	
		FOREARM			PELVIS	
		HAND			SHOULDER	
		HIP		X	WRIST	
		LUMBAR SPINE			CERVICAL SPINE	
		MAMMOGRAM			TIB-FIB	

OTHER, as follows... carpal tunnel view (for hamate fx)

Cardiology & Neurological Services

	EKG		GXT		GXT w/THALLIUM
	HOLTER		2-D ECHO		2-D COLOR DOPPLER
	EEG		STRESS ECHO		

OTHER, as follows...

Misc. Additional Orders and/or Diagnosis

PLAINTIFF'S EXHIBIT 14e
Blumberg No. 5113